Dental Claim Form

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8. Patient Name (Last, First, Middle) 9. Address 10. City	11. State 16. Zip Code 32. Policy #
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12. Date of Birth (MM/DD/YYYY) 13. Patient ID #	16. Zip Code
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17. Helationship to Subscriber/Employee: Self Spouse Child Other Name Address 19. Subs./Emp. ID#/SSN# 20. Employer Name 21. Group # 31. Is Patient covered by another plan 32. Po	32. Policy #
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□ No (Skip 32-37) □ Yes: □ Dental or □ Medical	
22. Subscriber/Employee Name (Last, First, Middle) One (Skip 32-37)	☐ Medical
22. Subscriber/Employee Name (Last, First, Middle)	
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23. Address 24. Phone Number 5 34. Date of Birth (MM/DD/YYYY) 35. Sex 36. Plan/Pro	Sex 36. Plan/Program Name
23. Address 24. Phone Number () 34. Date of Birth (MM/DD/YYYY) 35. Sex 36. Plan/Proj	=
25. City 26. State 27. Zip Code 37. Employer/School	
Name Address 28. Date of Birth (MM/DD/YYYY) 29. Marital Status 30. Sex 38. Subscriber/Employee Status	#SS
23. Address 24. Phone Number () 34. Date of Birth (MM/DD/YYYY) 35. Sex 36. Plan/Proiding 37. Employer/School 37. Employer/School 38. Subscriber/Employee Status 38. Subscriber/Employee Status 39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating 40. Employer/School 40. Em	Student Part-time Student
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all 40. Employer/School	otaaott
dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such NameAddress	
charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. 41. I hereby authorize payment of the dental benefits otherwise payable to need to this claim.	
xx	
Signed (Patient/Guardian) Date (MM/DD/YYYY) Signed (Employee/subscriber)	
42. Name of Billing Dentist or Dental Entity 43. Phone Number 44. Provider ID # 45. Dentist Soc. Sec.	
	ofits otherwise payable to me directly to the
40 Address 4 40 Disease 4 40 Di	parties otherwise payable to me directly to the Date 45. Dentist Soc. Sec. or T.I.N.
	Date 45. Dentist Soc. Sec. or T.I.N. 49. Place of treatment
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